STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - REHABILITATIVE SERVICES

Psychiatric Residential Rehabilitation includes the following components:

1. Community living skills and daily living skills development;
2. Client skills development for self-administration of medication, as well as recognition of signs of relapse and control of symptoms; and
3. Skill-building in the use of public transportation when appropriate.

A psychiatric residential rehabilitation provider must be licensed as a residential care facility, a domiciliary, or a mental health center by the Nebraska Department of Health. The maximum capacity for this facility must not exceed eight beds. A waiver up to a maximum of ten beds may be granted when it is determined to be in the clients' best interests. Facilities under contract with the Department prior to the approval of this plan amendment whose capacity exceeds the ten-bed limitation will be exempted from this requirement, except that bed capacity can never exceed 16 beds.

Telehealth:

Rehabilitative services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – SERVICES FOR INDIVIDUALS AGE 65 OR OLDER IN INSTITUTIONS FOR MENTAL DISEASES – INPATIENT HOSPITAL SERVICES

Telehealth:

Inpatient hospital services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended.

ATTACHMENT 3.1-A
Item 14b
Applies to Both Categorically and Medically Needy

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – SERVICES FOR INDIVIDUALS AGE 65 OR OLDER IN INSTITUTIONS FOR MENTAL DISEASES – SKILLED NURSING FACILITY SERVICES

Telehealth:

Skilled nursing facility services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended. Physician visits to clients required on the specific periodic schedule for nursing facility certification are excluded.

Transmittal # MS-00-06

Supersedes Approved MAR 16 2001 Effective JUL 1 2000

Transmittal # new page

ATTACHMENT 3.1-A
Item 14c
Applies to Both Categorically and Medically Needy

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – SERVICES FOR INDIVIDUALS AGE 65 OR OLDER IN INSTITUTIONS FOR MENTAL DISEASES – INTERMEDIATE CARE FACILITY SERVICES

Telehealth:

Intermediate care facility services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended.

Transmittal # MS-00-06

Supersedes Approved MAR 1 0 2001 Effective JUL – 1 2000

Transmittal # new page

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: Nebraska

LIMITATIONS – ICF/MR SERVICES

ICF services may be provided to an indivudual with the diagnosis of mental retardation, cerebral palsy, epilepsy, or autism under the following conditions:

1. When medical conditions are the primary need of the client and preclude participation and habilitative training;
2. Documentation and an independent assessment of functional living skills (requested by the DPW Medical Review Team) has determined that training needs can adequately be met within an ICF level of care, and services can actually be delivered by the facilities;
3. The person is integrated into a normal environment and no longer needs extensive habilitative training pursuant to documented evidence as shown by the above assessment(s); and
4. The evaluation of appropriateness and the adequacy of services is based on review by the Medical Review Team with consideration of:
   a. An annual assessment of the client's functional living skills by a QMRP independent of the facility in which the client resides; and
   b. Incorporation of recommendations by the QMRP and Medical Review Team relative to training and/or further evaluation into the client's overall plan of care.

LIMITATIONS - ASSESSMENTS OF DEVELOPMENTALLY DISABLED PERSONS

Individuals having a developmental disability who currently reside in a non-MR facility shall, when identified as appropriate by the Medical Review Team, have an initial and subsequent annual independent assessment for functional living skills. Assessment of functional living skills shall be given to only clients identified by the Medical Review Team as appropriate for assessment based on the developmental disability criteria in order to:

1. Identify the most appropriate services to meet the identifying needs based on the principle of normalization, the least restrictive alternatives, and the client's needs.
2. The evaluation shall include actual observation/interview with the client and identify the sources of information including the staff persons who have supplied assessor with information relative to the assessment.
3. The assessment shall be an assessment of independent functioning of the individual. The assessment shall include recommendations for further evaluation and/or consultation in specific areas. Recommendations shall be incorporated into the individual's overall plan of care by the facility.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: Nebraska

LIMITATIONS – ICF/MR SERVICES

The following limitations are placed on ICF/MR services within the State of Nebraska:

1. ICF/MR services are appropriate for persons with related conditions. A person with related conditions is defined as: An individual with a disability attributed to mental retardation, cerebral palsy, epilepsy or autism; which disability originates before such individual achieves age 22; has contributed or can be expected to continue indefinitely, with function limitations in three or more of the following major life areas: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency. These limitations indicate that the client needs a combination of individually planned and coordinated special interdisciplinary care, treatments, or other services which are of lifelong or extended duration.
2. ICF/MR services are inappropriate when the individual is no longer benefiting from "active treatment" as indicated by sufficient documentation within the ICF/MR facility, and the individual is referred for alternative services which most appropriately meets needs in the most normalized living situation possible.
3. ICF/MR services are inappropriate when mental illness is a primary handicap of the individual to live in an independent living situation within a normalized environment.

Admission Procedures to ICF/MR Facility: Persons eligible to receive services provided by other agencies and other levels of care shall be acknowledged as inappropriate admissions; and

1. At the time of pre-admission meetings, plans shall be initiated to actively explore alternatives on an ongoing basis;
2. Agencies and levels of care shall be identified, contacted, and given information pertinent to meeting the client's needs.

The ICF/MR shall request identified agencies to:

1. Identify the appropriateness of their services;
2. Determine the actual availability of their services; and
3. Work with the facility in exploring alternatives.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: Nebraska

LIMITATIONS – ICF/MR SERVICES

Qualified Mental Retardation Professional Qualifications

Has experience in treating or working with the mentally retarded defined as: treating and/or dealing directly with persons who are mentally retarded, and demonstrates the ability to:

1. Apply the developmental model and normalization principle in training;
2. Write objectives and goals in a training program;
3. Conduct/carry out a training program;
4. Evaluate, document, and summarize the training program;
5. Assess the need for specific goals and objectives.

It is necessary to indicate the dates when this experience occurred.

If qualifying as having a Bachelor's Degree and working three years under a qualified social worker, it is necessary to indicate:

1. Name of supervisor
2. Supervisor's qualifications as a social worker
3. How, the supervision was done
4. The period of time supervision was done

Individuals desiring recognition as a QMRP must submit information in writing regarding their qualifications (specifying dates, places, types of experience/training, and supervisor training/experience) to the Department of Health and Human Services Regulation and Licensure, Division of Standards, and/or Department of Health and Human Services Finance and Support, Medicaid Division, Long Term Care Unit. The information will be reviewed and approved or disapproved.

Telehealth:

ICF/MR services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: Nebraska

LIMITATIONS – ICF/MR SERVICES

The Department applies the following criteria to determine the appropriateness of ICF/MR services on admission and at each subsequent review:

1. The client has medical needs which require the ICF level of care; and
2. The client has a developmental disability which has been confirmed by prior diagnostic evaluations and sources independent of the ICF/,14R; and
3. The client can benefit from "active treatment" as defined in 42 CFR 435.1009 and 471 MAC 31-001.02. "Benefit from active treatment" means demonstrable progress in reducing barriers to less restrictive alternatives.
4. In addition, the following criteria shall apply in situations where -
   a. The client has a developmental disability other than mental retardation and the QMRP's assessment identifies that the developmental disability has resulted in substantial functional limitations in three or more of the following areas of major life activity:
      (1) self-care;
      (2) receptive and expressive language;
      (3) learning;
      (4) mobility;
      (5) self-direction; or
      (6) capacity for independent living.

      These substantial functional limitations indicate that the client needs a combination of individually planned and coordinated special interdisciplinary care, treatment, or other services which are lifelong or of extended duration; and/or

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: Nebraska

LIMITATIONS – ICF/MR SERVICES

b. A client has a dual diagnosis of developmental disability and a mental illness (i.e. , mental retardation and schizophrenia) and developmental disability has been verified as the primary diagnosis by both an independent QMRPs assessment and a mental health professional (psychologist); and
(1) Historically there is evidence of missed stages of developmental tasks, due to developmental disability;
(2) There is remission in the mental illness and/or it does not interfere with intellectual functioning and participation in training programs (i.e., the client does not have active hallucinations nor exhibit behaviors which are manifestations of mental illness); and
(3) The developmental disability takes precedence over the diagnosis of mental illness.

Inappropriate Placements: The following examples are not appropriate for ICF/MR services according to the criteria listed previously.

1. Mental illness is the primary barrier to independent living within a normalized environment; or
2. The ICF/MR is not the least restrictive alternative, e.g., the client:
   a. Exhibits skills and needs comparable to those of persons living independently or semi-independently in the community; or
   b. Exhibits skills and needs comparable to those of persons at chronic, SNF, or ICF level of care.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: Nebraska

LIMITATIONS – ICF/MR SERVICES

Admission procedures to ICF/MR facility: Persons eligible to receive services provided by other agencies and other levels of care shall be acknowledged as inappropriate admissions; and

1. At the time of pre-admission meetings, plans shall be initiated to actively explore alternatives on an ongoing basis;
2. Agencies and levels of care shall be identified, contacted, and given information pertinent to meeting the client's needs.

The ICF/MR shall request identified agencies to:

1. Identify the appropriateness of their services;
2. Determine the actual availability of their services; and
3. Work with the facility in exploring alternatives.

Qualified Mental Retardation Professional Qualifications

Has experience in treating or working with the mentally retarded defined as: treating and/or dealing with persons who are mentally retarded, and demonstrates the ability to:

1. Apply the developmental model and normalization principle in training;
2. Write objectives and goals in a training program;
3. Conduct/carry out a training program;
4. Evaluate, document, and summarize the training program;
5. Assess the need for specific goals and objectives.

It is necessary to indicate the dates when this experience occurred.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: Nebraska

LIMITATIONS – ICF/MR SERVICES

If qualifying as having a Bachelor's Degree and working three years under a qualified social worker, it is necessary to indicate:

1. Name of supervisor;
2. Supervisor's qualifications as a social worker;
3. How the supervision was done; and
4. The period of time supervision was done.

Individuals desiring recognition as a QMRP for conducting QMRP assessment must submit information in writing regarding their qualifications (specifying dates, places, types of experience/training, and supervisor training /experience) to Department of Health and Human Services Finance and Support, Medicaid Division. The information will be reviewed and approved or disapproved.

Telehealth: ICF/MR services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – INPATIENT PSYCHIATRIC FACILITY SERVICES FOR INDIVIDUALS UNDER AGE 21

NMAP limits coverage of inpatient psychiatric facility services for client age 20 or younger to those services that are medically necessary to treat primary diagnoses. This service is covered under 42 CFR 441, Subpart D. NMAP covers these services when they are medically necessary and provide active treatment.

Inpatient psychiatric facility services include inpatient mental health and substance abuse services provided to clients age 20 or younger when the client participates in an EPSDT screen and the treatment is medically necessary.

These services may be provided by the following inpatient psychiatric facilities:

1. A hospital or IMD;
2. A residential treatment center that is accredited by JCAHO; or
3. A treatment group home that is JCAHO-accredited.

Providers are required to meet the standards for participation listed in the appropriate section Chapter 32-000 of 471 NAC.

Telehealth:

Inpatient psychiatric facility services for individuals under age 21 are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended.

Attachment 3.1-A
Item 17
Applies to both Categorically
and Medically Needy

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - NURSE-MIDWIFE SERVICES

To participate in the Nebraska Medical Assistance Program, the nurse-midwife must be certified by the Department of Health and Human Services Regulation and Licensure. The practice agreement between the nurse-midwife and the physician with whom s/he has a practice agreement must be on file with the Department of Health and Human Services Regulation and Licensure. The nurse-midwife is approved for enrollment in NMAP under an independent provider agreement or the provider agreement of the physician with whom s/he has a practice agreement.

NMAP covers nurse-midwife services that are medically necessary and are concerned with the management of the care of mothers and newborns throughout the maternity cycle. The maternity cycle includes pregnancy, labor, birth, and the immediate postpartum period (up to six weeks), including care of the newborn. To be covered, the services must be provided by a certified nurse-midwife according the terms of the practice agreement between the nurse-midwife and the physician.

NMAP does not cover any other services provided by nurse-midwives.

Telehealth:

Nurse-midwife services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended. Services requiring "hands on" professional care are excluded.

Attachment 3.1-A
Item 20a
Applies to Both
Categorically and
Medically Needy

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - PREGNANCY-RELATED AND POSTPARTUM SERVICES FOR 60 DAYS AFTER THE PREGNANCY ENDS

NMAP covers pregnancy-related and postpartum services for 60 days after the pregnancy ends or at the end of the month in which the 60th day falls, based on medical necessity.

Telehealth:

Pregnancy-related and postpartum services are provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended.

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Supercedes Approved MAR 1 8 2001 Effective JUL 1 2000

Transmittal # MS-86-25

Attachment 3.1-A
Item 20b
Applies to Both
Categorically and
Medically Needy

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - SERVICES FOR ANY OTHER MEDICAL CONDITIONS THAT MAY COMPLICATE PREGNANCY

NMAP covers medical services for any other medical conditions that may complicate pregnancy, based on medical necessity.

Telehealth:

Medical services for medical conditions that may complicate pregnancy are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended.

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Transmittal # MS-86-25

ATTACHMENT 3.1-A
Item 23
Applies to Both
Categorically and
Medically Needy

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – CERTIFIED PEDIATRIC OR FAMILY NURSE PRACTITIONERS' SERVICES

Telehealth:

Certified pediatric or family nurse practitioners' services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended.

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Supercedes Approved MAR 16 2001 Effective JUL 1 2000

Transmittal # new page

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - TRANSPORTATION

AMBULANCE

NMAP covers medically necessary ambulance services required to transport a client during an emergency or required to obtain medical care. Emergency ambulance transports to a physician or practitioner's office, clinic or therapy center are covered. Non-emergency ambulance transports to a physician or practitioner's office, clinic or therapy center are covered when –

1. The client is bed confined before, during, and after transport; and
2. The services cannot or cannot reasonably be expected to be provided at the client's residence (including a nursing facility or ICF/MR).

OTHER MEDICAL TRANSPORTATION

NMAP enrolls individual and agency providers to provide appropriate medical transportation to Medicaid-eligible clients. NMAP covers transportation services for Medicaid-eligible clients for trips necessary to obtain Medicaid-coverable services when the client has no other means of transportation. NMAP may cover transportation services for a parent, caretaker, or attendant to escort a client to and from Medicaid-coverable services when necessary.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - TRANSPORTATION

AMBULATORY ROOM AND BOARD

NMAP covers ambulatory room and board services as a travel-related expense under 42 CFR 440.170(a)(3)(ii) and (iii). Ambulatory room and board is defined as meals and lodging determined to be necessary by Medicaid Division staff to secure NMAP-coverable services for a Medicaid client.

This may include meals and lodging for an attendant.

NMAP covers ambulatory room and board services only when:

1. The client is receiving NMAP-coverable services;
2. Travel time or distance to the medical provider and receipt of medical services are expected to require the client to be away from his/her home for 12 hours or longer;
3. An out-of-town overnight stay is necessary while receiving NMAP-coverable services; and
4. Ambulatory room and board is a cost effective level of care that provides an alternative to inpatient admission or extended outpatient care.

Ambulatory room and board services may be covered for up to one day before or after receiving NMAP-coverable services, if extensive travel is necessary to receive NMAP-coverable services. Ambulatory room and board for an attendant to accompany the client may be covered when the client is physically or mentally unable to travel or wait alone while receiving NMAP-coverable services.

To be eligible to receive NMAP payment for ambulatory room and board services, each hospital providing those services must be approved by the Medicaid Division as a provider of ambulatory room and board services before providing these services to NMAP clients and/or attendants.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - TRANSPORTATION

Telehealth:

Medical transportation services, including ambulance services and ambulatory room and board, are not covered when provided via telehealth technologies.

ATTACHMENT 3.1-A
Item 24d
Applies to Both
Categorically and
Medically Needy

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – NURSING FACILITY SERVICES FOR PATIENTS UNDER 21 YEARS OF AGE

Telehealth:

Nursing facility services for patients under 21 years of age are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended. Physician visits to clients in nursing facilities required on the specific periodic schedule for nursing facility certification are excluded.

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Transmittal # new page

ATTACHMENT 3.1-A
Item 24e
Applies to Both
Categorically and
Medically Needy

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – EMERGENCY HOSPITAL SERVICES

Telehealth:

Emergency hospital services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended.

ATTACHMENT 3.1-A
Item 26
Applies to Both
Categorically and
Medically Needy

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - PERSONAL CARE AIDE SERVICES

NMAP covers personal care aide services when ordered by the client's physician based on medical necessity.

NMAP generally limits personal care aide services to 40 hours per client per seven-day period, subject to utilization review. Medicaid Division approval must be obtained for services authorized in excess of 40 hours per week.

NMAP considers a personal care aide to be a "trained" aide when the provider meets one of the following criteria and presents a copy of the certificate or license to the worker. The provider must:

1. Have successfully completed the American Red Cross Home-Bound Care Course or a basic aide training course that has been approved by the Nebraska Health and Human Services System;
2. Have passed the Nurse Aide Equivalency test; or
3. Be a licensed R.N. or L.P.N.

Telehealth:

Personal care aide services are not covered when provided via telehealth technologies.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Payment for Outpatient Hospital and Emergency Room Services: For services provided on or after July 1, 1992, the Department pays for outpatient hospital and emergency services with a rate which is the product of -

1. Eighty-five percent of the cost-to-charges ratio from the hospital's latest Medicare cost report (Form HCFA-2552-89, Pub. 15-II, Worksheet C); multiplied by
2. The hospital's submitted charges on Form HCFA-1450 (UB-92).

The effective date of the cost-to-charges percentage is the first day of the month following the Department's receipt of the cost report.

Providers shall bill outpatient hospital and emergency room services on Form HCFA-1450 (UB-92) in a summary bill format. Providers shall not exceed their usual and customary charges to non-Medicaid patients when billing the Department.

Exception: All outpatient clinical laboratory services must be itemized and identified with the appropriate HCPCS procedure codes. The Department pays for clinical laboratory services on the fee schedule determined by HCFA.

Payment for Outpatient Hospital and Emergency Room Services Provided by Critical Access Hospitals: Effective for cost reporting periods beginning after July 1, 1999, payment for outpatient services of a CAH is the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except that the following principles do not apply: the lesser of costs or charges (LCC) rule and the reasonable compensation equivalent (RCE) limits for physician services to providers. NMAP will adjust interim payments to reflect elimination of any fee schedule methods for specific services, such as laboratory or radiology services, that were previously paid for under those methods. Payment for these and other outpatient services will be made in accordance with reasonable cost principles. Professional services must be billed by the physician or practitioner using the appropriate physician/practitioner provider number, not the facility's provider number. To avoid any interruption of payment, NMAP will retain and continue to bill under existing provider numbers until new CAH numbers are assigned.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Payment to Hospital-Affiliated Ambulatory Surgical Centers: The Department pays for services provided in an HAASC according to Payment for Outpatient Hospital and Emergency Room Services, unless the HAASC is a Medicare-participating ambulatory surgical center (ASC). If the HAASC is a Medicare-participating ASC, payment is made according to Medicare methods.

Approval of Payment for Emergency Room Services: At least one of the following conditions must be met before the Department approves payment for use of an emergency room:

1. The patient is evaluated or treated for a medical emergency, accident, or injury (see definition of medical emergency in 471 NAC 10-001.02);

2. The patient's evaluation or treatment in the emergency room results in an approved inpatient hospital admission (the emergency room charges must be displayed on the inpatient claim as ancillary charges and included in the inpatient per diem); or
3. The patient is referred by a physician such as for allergy shots or when traveling (a written referral by the physician must be attached to the claim);

The facility should review emergency room services and determine whether services provided in the emergency room constitute an emergency and bill accordingly.
When the facility or the Department determine services are non-emergent, the room fee for non-emergent services provided in an emergency room will be disallowed to 50 percent of the applicable ratio of cost-to-charges. All other Medicaid allowable charges incurred in this type of visit will be paid at 85% of the ratio of cost-to-charges.

Diagnostic and Therapeutic Services: The payment rate for diagnostic and therapeutic services includes payment for services required to provide the service. Extra charges, such as stat fees, call-back fees, specimen handling fees, etc., are considered administrative expenses and are included in the payment rate.

Payment to a New Hospital for Outpatient Services: See the definition of a new operational facility in 471 NAC 10-010.03A. Payment to a new hospital (a new operational facility) will be made at 85% of the statewide average ratio of cost to charges for Nebraska hospitals as of July 1 of that year as determined by the Department. This payment is retrospective for the first reporting period for the facility. This ratio will be used until the Department receives the hospital's initial cost report. The Department shall cost-settle claims for Medicaid-covered services which are paid by the Department using 85% of the statewide average ratio of cost to charges. The cost settlement will be the lower of cost or charges as reflected on the hospital's cost report (i.e., the Department's payment must not exceed the upper limit of the provider's charges for services).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Upon the Department's receipt of the hospital's initial Medicare cost report, the Department shall no longer consider the hospital to be a "new hospital" for payment of outpatient services. The Department shall determine the ratio of cost to charges from the initial cost report and shall use that ratio to prospectively pay for outpatient services. (For a complete description of payment for outpatient services, see 471 NAC 10-010.06 ff.)

Payment to An Out-of-State Hospital for Outpatient Services: Payment to an out-of-state hospital for outpatient services will be made based on the statewide average ratio of cost to charges multiplied by 54 for all Nebraska hospitals for that fiscal year as of July 1 of that year.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for the line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two-way interactive audio-visual transmission as set forth in state regulations, as amended.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

RURAL HEALTH CLINICS

NMAP pays for Rural Health Clinic (RHC) services provided by provider-based RHCs associated with hospitals of 50 beds or more at the reasonable cost rate per visit as established by Medicare. NMAP pays for RHC services provided by provider-based clinics associated with hospitals under 50 beds at the lower of cost or charges, as established by Medicare. For those non-RHC services for which no charge has been established by Medicare, NMAP makes payment according to the Nebraska Medicaid Practitioners Fee Schedule.

A provider-based RHC is defined as an integral part of a hospital, nursing facility, or home health agency that is participating in Medicare and is licensed, governed, and supervised with departments of the facility.

NMAP pays for RHC services provided by Independent RHCs at the reasonable cost rate per visit as established by Medicare. For those non-RHC services for which no charge has been established by Medicare, NMAP makes payment according to the Nebraska Medicaid Practitioners Fee Schedule.

The annual cost settlement will be calculated for each provider-based RHC associated with hospitals of 50 beds or more and Independent RHCs using the Medicare approved encounter rate multiplied by the number of encounters (all services per recipient per day is one encounter). This figure is compared to the total amount paid for services during the cost settlement period and facilities are paid the lower amount. Reimbursement for clinical laboratory and radiology services is included in the encounter rate.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service. RHC core services provided via teleheatlh technologies are not covered under the encounter rate. See Attachment 3.1A, Item 2b.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The provider must be in compliance with the standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

FEDERALLY-QUALIFIED HEALTH CENTERS

The Nebraska Medical Assistance Program (NMAP) makes payment for services provided by federally-qualified health centers (FHQCs) as defined in section 1905(a)(2)(C) of the Social Security Act on the basis of 100 percent of reasonable costs attributed to the care of Medicaid-eligible clients, as established by the Nebraska Department of Health and Human Services Finance and Support.

Reasonable costs are determined by the Department on the basis of the FQHCs cost report, submitted as the Medicare cost report (Form HCFA-2552) or any other cost reporting form approved by the Department for this use. Such costs cannot exceed the reasonable costs as determined by the applicable Medicare cost reimbursement principles set forth in 42 CFR Part 413.

Providers participating in the NMAP as FQHCs must submit to the Department a plan for allocating costs to the Medicaid program. This plan must also indicate the annual cost reporting period by which the FQHC plans to report its annual costs to the Department.

The Department will make interim payments to the FQHC during its cost reporting period. The interim payments will be the amounts normally paid to the FQHC under the Nebraska Medicaid Practitioner Fee Schedule, and will be subject to reconciliation at the end of the cost reporting period. Following the receipt of the FQHCs annual Medicare cost report (or other acceptable cost reporting form), the Department will compute a retroactive adjustment to the annual allowable Medicaid costs as reported by the FQHC. The Department will make additional payment to the FQHC when the allowable reported annual Medicaid costs exceed the sum of the payments made to the FQHC under the Nebraska Medicaid Practitioner Fee Schedule for the cost reporting period. Payment adjustments will be made within 90 days of receipt of the cost report by the Department. The FQHC must reimburse the Department when its allowable reported Medicaid costs for the cost reporting period are less than the sum of the payments made to the FQHC under the Nebraska Medicaid Practitioner Fee Schedule for the cost reporting period. Adjustments owed to the Department must be made within 90 days following notice by the Department to the FQHC of the amount due.

Nebraska has determined and assures that payments to FQHCs are based upon and cover the reasonable costs of providing services to Medicaid beneficiaries.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service. FQHC core services provided via telehealth technologies are not covered under the encounter rate. See Attachment 3.1A, Item 2c.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs related to non-core services is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The provider must be in compliance with the standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.
